VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 30, 2012

Mr. James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **March 8, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

RECEIVED
Division of
MAR 2 8 12
Licensing and Protection

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	C 03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWAN COURT HEALTH & REHAB	378 PROSPECT STREET BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was completed by the Division of Licensing and Protection on 3/8/12. The following are regulatory violations.	F 000		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that residents are free of any significant medication errors for 1 applicable resident in the sample. (Resident #1) Findings include: Per record review and interview, Resident #1 was given all of his roommate's morning medications at 9 AM on 2/3/12. The medications given were as follows: Seroquel (an anti-psychotic) 300 milligrams (mg), Ativan (an anti-anxiety) 0.5 mg, Lasix (a diuretic) 60 mg, Lisinopril (blood pressure medication) 10 mg, Imdur (heart medication) 30 mg, Colace (stool softener) 100 mg, Miralax (stool softener) 17 grams, Plavix (blood-thinner) 75 mg, Aspirin (has blood-thinning effects) 325 mg, Cymbalta (an anti-depressant) 60 mg, Fenofibrate (cholesterol lowering medication), and Vitamin B12. The Miralax and Lasix were not errors, as this resident is prescribed the same doses of those medications. The error was identified immediately after administration of the incorrect medications and appropriate actions were taken by the nurse per	F 333	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3/23/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 333	Continued From page 1 the facility policy. Per interview on 3/8/12 at 2:55 PM, the involved nurse stated that prior to the administration of the medication, s/he checked the picture of the resident in the record and the resident identified him/herself as the roommate when asked if s/he was the roommate. Per the nurse, the roommates' pictures were similar. However, residents at this facility wear wristbands, and during the same interview, the nurse confirmed that s/he did not verify the resident's identity using the wristband prior to administering mediation (see policy information below). Per review of the nurses' notes, the resident became "very sleepy and slurring [his/her] words" and was sent to the Emergency Department at the local hospital at about 10:30 AM for evaluation and was admitted to the Intensive Care Unit. Per CMS definitions, a "significant medication error" is one which causes the resident discomfort or jeopardizes his or her health and safety. Resident #1 was on warfarin (blood thinner) therapy, which has a narrow therapeutic range. In addition to the warfarin administered per physician's orders the evening on 2/2/12, Resident #1 received 2 additional medications with blood thinning effects as part of the error on 2/3/12 (Plavix and aspirin). Per review of hospital laboratory results, Resident #1's INR (International Normalized Ratio), a test to determine whether patients receiving warfarin are in the therapeutic range, was reported as critically high at 13.2 at 2:10 PM on 2/3/12 (therapeutic range is typically 2.0-3.0). The equipment at the hospital was not able to read the test because of the critically high level, and	F 333		

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F 333	Continued From page 2 the test had to be read at another acute care hospital with different equipment. Per review of hospital documentation, a CAT scan of the head was performed due to the result of the INR being "too high to read" and the risk of intracranial (brain)bleeding. Also, intramuscular and intravenous Vitamin K was required to reverse the effects of the blood thinning medication. Per review of laboratory results, the last INR , prior to the medication errors was 2.4 on 1/30/12. Per manufacturer's Prescribing information, adverse reactions to Seroquel include somnolence and lethargy (drowsiness), both of which were documented by the hospital as symptoms Resident #1 was displaying. The starting recommended dose of Seroquel is 25 mg. Resident #1 received 300 mg and had not received this medication prior to the medication error. Per the policy titled "Administering Medications", it states "the individual administering the medication must verify the resident's identity before administering the medication. (See policy entitled Resident Identification System.)" Per the policy titled "Resident Identification System", the facility has adopted a photo and wristband identification system to assist the facility in assuring that medication is administered to the right resident. Past noncompliance was determined to exist due to the facility completing corrective action prior to the onsite investigation. The facility was cited for Significant Medication Errors in January 2012 and a follow up was completed on 2/14/12 which determined that the facility had corrected the	F 333		

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F 333	Continued From page 3 deficiency. However, this medication error that occurred on 2/3/12 was not disclosed to the follow up survey team, so was not reviewed on 2/14/12 as part of the follow up. The 2/14/12 survey determined that the facility had provided the required inservice education regarding significant medication errors, no medication errors were reported to the team, and no medication errors were observed. During this 3/8/12 onsite complaint investigation, an additional medication pass observation was conducted which examined 9 residents and 22 medications given with no errors observed, confirming current compliance. Reference: Seroquel: Highlights of Prescribing Information. http://www1.astrazeneca-us.com/pi/Seroquel.pdf. Accessed March 15, 2012.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 4 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, staff failed to follow infection control guidelines to prevent spread of infection and failed to follow infection control guidelines in regards to administration of injections for 2 of 9 residents in the sample. (Residents #2 and #3) Findings include: 1. Per observations on 3/8/12 from 3:40 PM to 3:50 PM, Nurse #1 failed to follow the facility's infection control expectations when providing care and services to Resident #2, who is on contact precautions for an active infection. A sign outside of Resident #2's room states "STOP; Before entering please do the following; See	F 441	No residents were harmed as a result of this alleged deficiency. All residents who may have a communicable disease have the potential to be affected by this alleged deficiency. The nurse who was giving care while this tag was documented no longer works for the facility; she was employed by an agency and her contract has been completed. All nurses will be in-serviced in proper infection control procedures, esp. in regard to; hand washing with C-diff.; use of equipment and supplies for residents in isolation; and use of gloves while giving injections. The DNS or designee will perform random audits of at least three (3) nurses once per week, for a period of 60 days, and will report the results once each month to the QA/QI Committee, times three (3) months. POC Completion date: March 30, 2012 F441 POC accepted 3/28/12 cMcotaPN	

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F 441	Continued From page 5 nurse; Wash hands; Apply mask; Apply gloves; Apply Gown". Per observation at 3:40 PM, Nurse #1 entered Resident #2's room without washing hands with soap and water and without wearing any of the Personal Protective Equipment (PPE) listed on the sign. Direct contact was made with the resident and surfaces in the resident's room and a small cart with vital sign equipment (blood pressure machine, blood pressure cuff, thermometer, etc.) was brought into the room at that time and placed by the resident. While Nurse #1 was in the room with no PPE and the vital sign cart was in view, the Interim Director of Nursing Services (IDNS) came to the doorway of the resident room to speak with the nurse, but did not mention anything about infection control concerns. In addition, Nurse #1 also brought in a clipboard and pen into the room that was then placed on the medication cart after exiting. Nurse #1 exited the room to provide medication for another resident, leaving the vital sign cart in Resident #2's room next to the resident. Nurse #1 did not wash hands with soap and water before or after leaving the room, only using sanitizer. After providing medication to another resident, Nurse #1 re-entered Resident #2's room without any PPE. The nurse took Resident #2's vital signs using the equipment on the vital sign cart, coming into direct contact with the resident and surfaces in the room. The nurse then exited Resident #2's room without washing hands with soap and water and placed the vital sign cart in the hallway. The nurse then continued with the medication administration to other residents accompanied by the surveyor until 4:25 PM. The vital sign cart was placed by an empty room where a new resident was expected to be	F 441		

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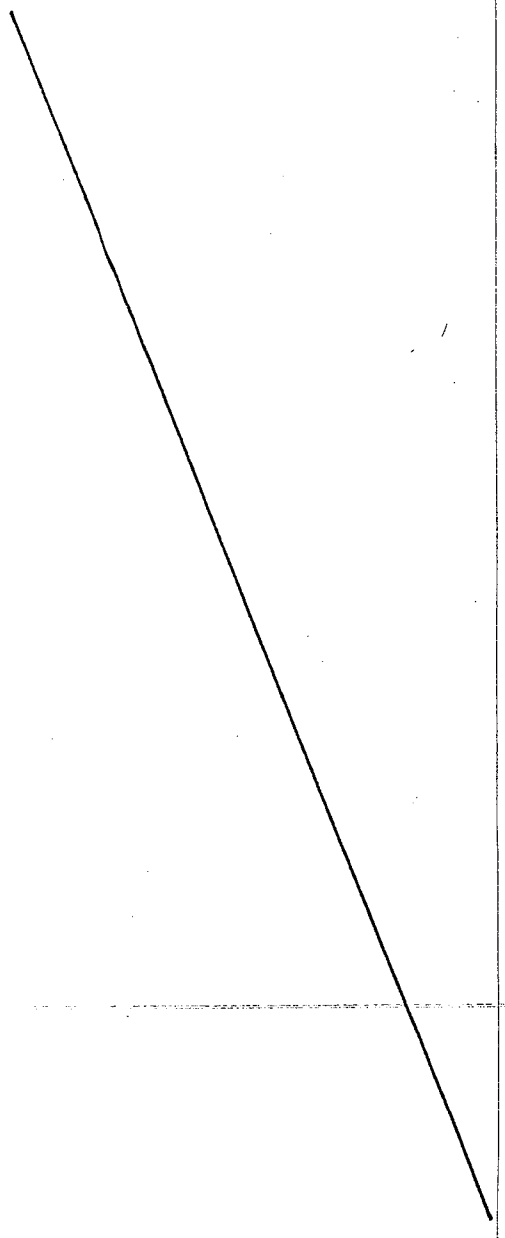
F 441	Continued From page 6 admitted. The cart and equipment were not cleaned and disinfected. Nurse #1 confirmed, immediately after the observation, that the resident is on contact precautions for Clostridium difficile infection, no PPE was worn and only sanitizer was used. Per record review, Resident #2 has an active diagnosis of Clostridium difficile and is currently on medication to treat the infection. Per interview on 3/8/12 at 4:25 PM, the Staff Development/Infection Control nurse verified that hands should to be washed with soap and water after providing care to this resident and that the vital sign equipment needs to be cleaned and disinfected and the equipment should not have been left in the hallway for potential use on other residents without being cleaned and disinfected. S/he did state that since the resident is alert and oriented and continent of stool, PPE is not required at all times if staff don't anticipate coming into contact with bowel movement material. 2. Per observation at 4:20 PM, Nurse #1 failed to wear gloves when administering 2 subcutaneous injections to Resident #3. The nurse placed her hand directly on Resident #3's right hip/groin area on the skin and administered the injections with the other hand after cleaning only the injection sites. The nurse then recapped both needles on the multi-use injection pens with the ungloved hands to dispose of the needles. The nurse confirmed, immediately after the observation, that no gloves were worn for the injections. Per review of facility policy titled "Injections, Subcutaneous" and confirmed with the former DNS at 4:45 PM on 3/8/12, gloves are required to	F 441		

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F 441	Continued From page 7 be worn for subcutaneous injections.	F 441		